STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

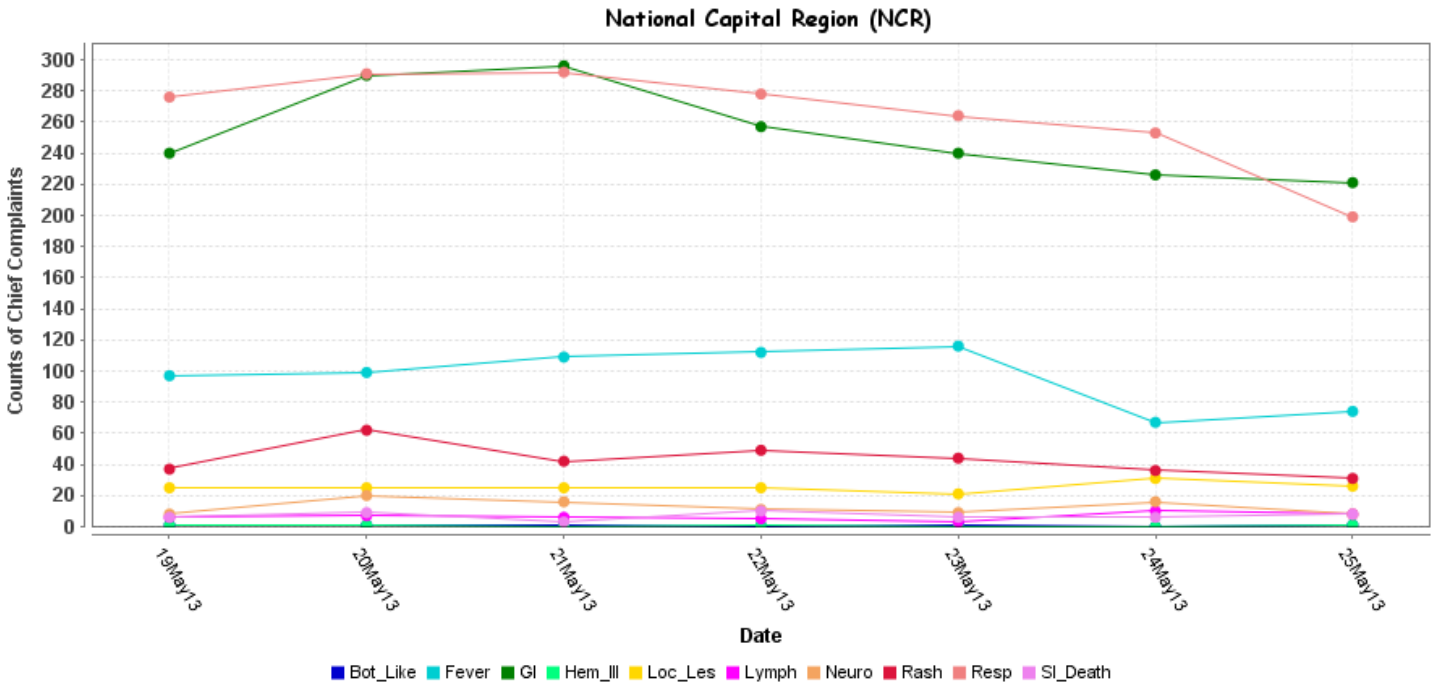
May 31, 2013

Public Health & Emergency Preparedness Bulletin: # 2013:21
Reporting for the week ending 05/25/13 (MMWR Week #21)

CURRENT HOMELAND SECURITY THREAT LEVELS

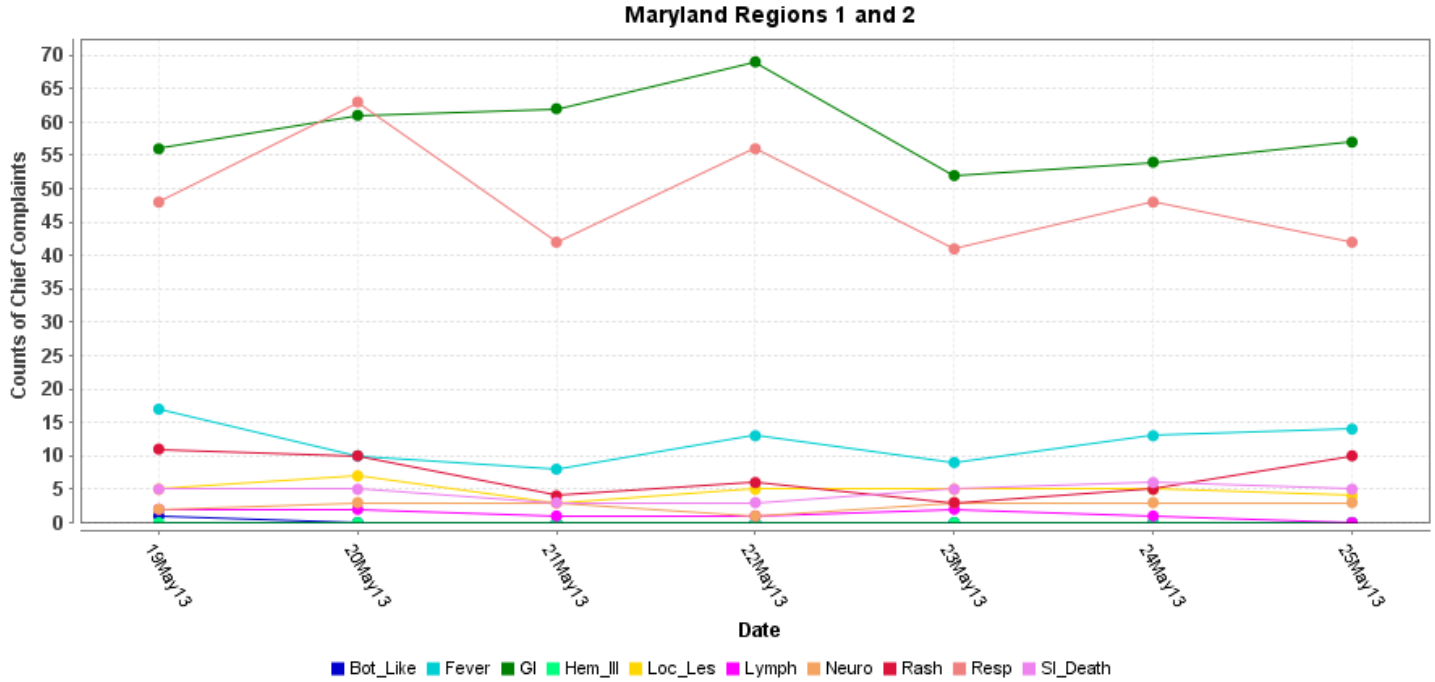
National: **No Active Alerts**
Maryland: **Level One (MEMA status)**

SYNDROMIC SURVEILLANCE REPORTS
ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics):
Graphical representation is provided for all syndromes, excluding the "Other" category, all age groups, and red alerts are circled. Red alerts are generated when observed count for a syndrome exceeds the 99% confidence interval. Note: ESSENCE – ANCR uses syndrome categories consistent with CDC definitions.
Overall, no suspicious patterns of illness were identified. Track backs to the health care facilities yielded no suspicious patterns of illness.

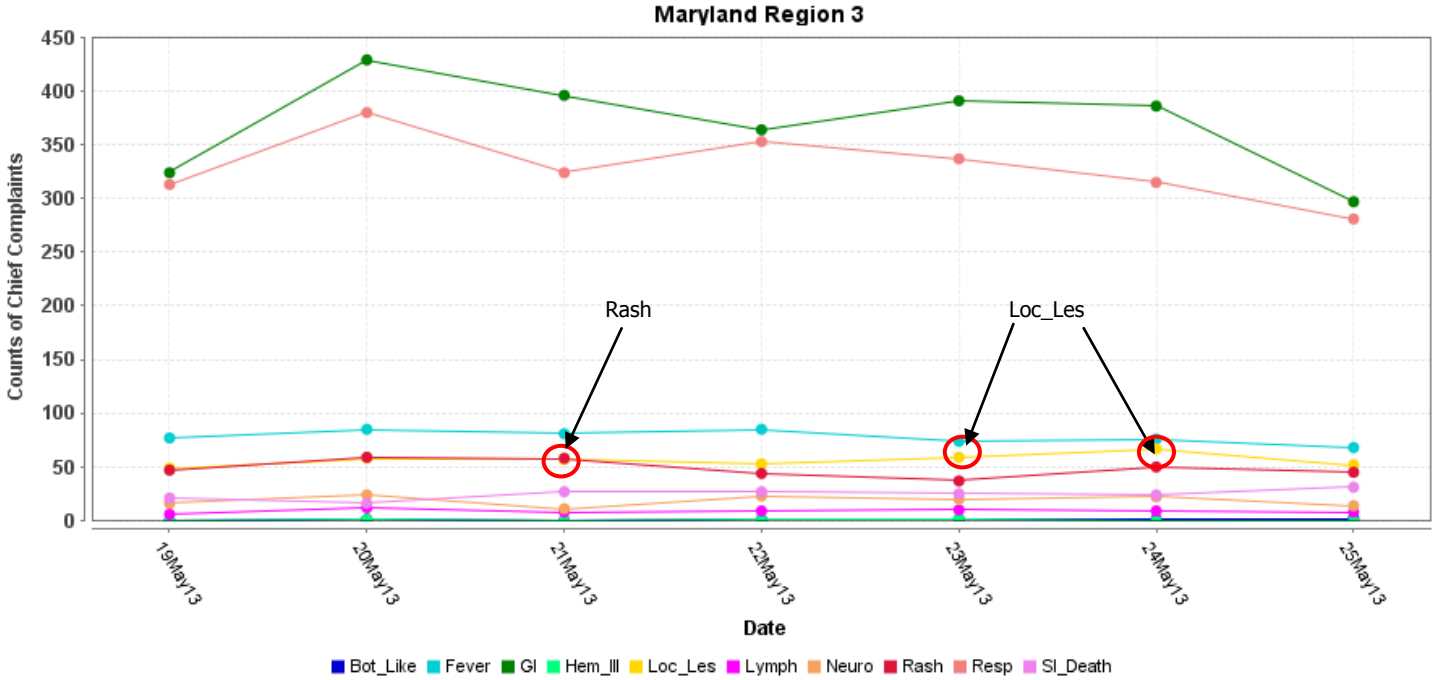


*Includes EDs in all jurisdictions in the NCR (MD, VA, and DC) reporting to ESSENCE

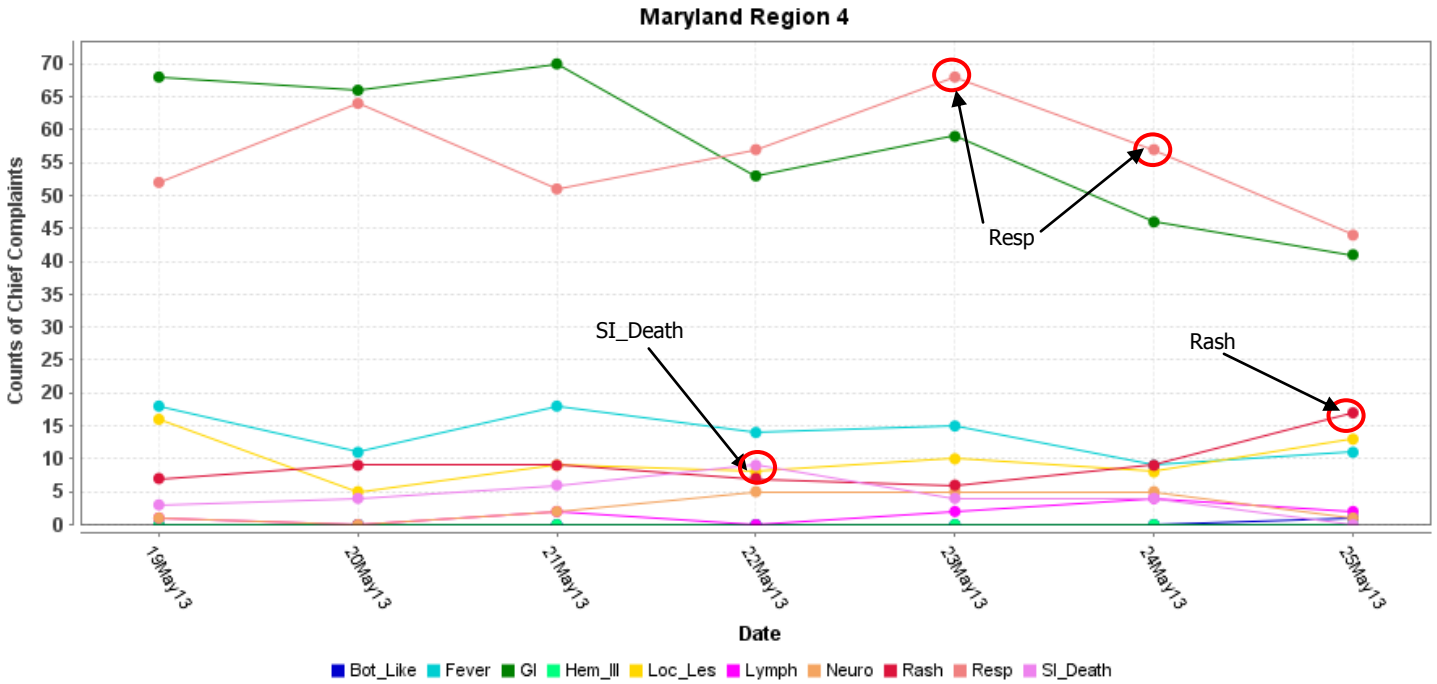
MARYLAND ESSENCE:



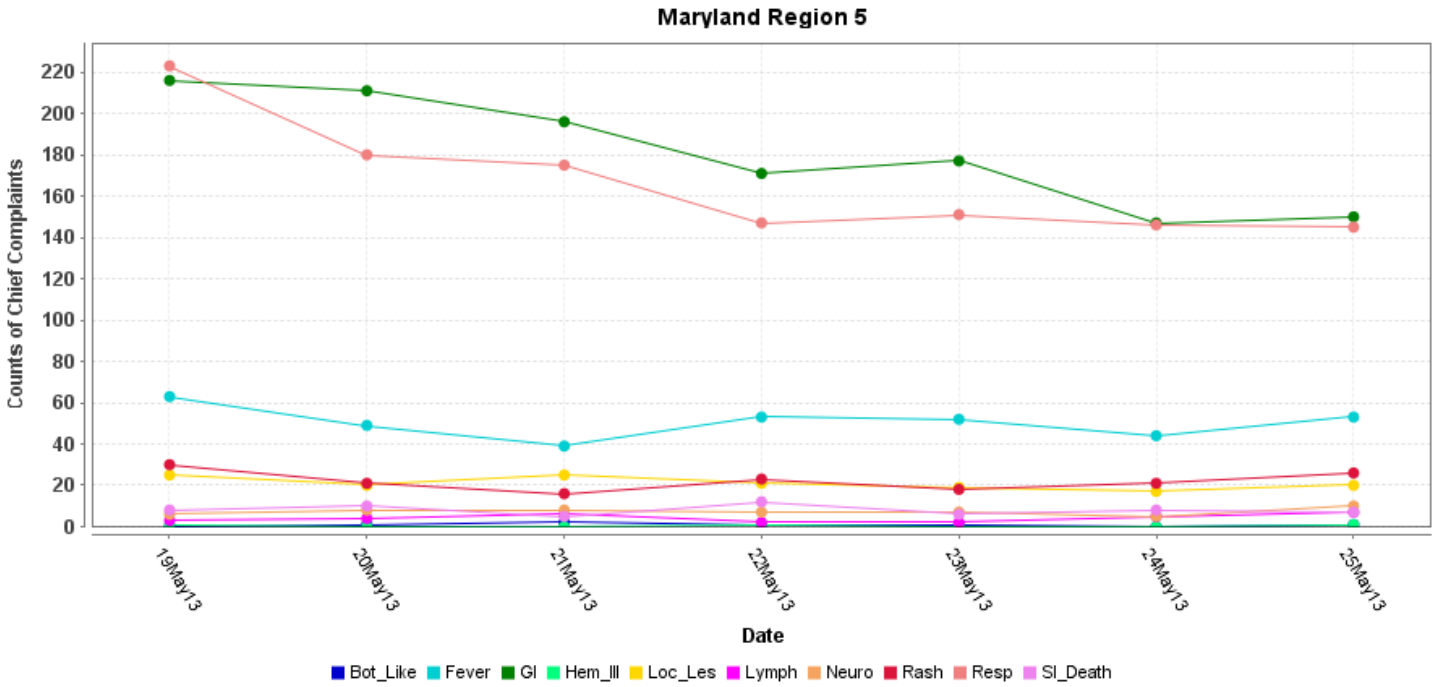
* Region 1 and 2 includes EDs in Allegany, Frederick, Garrett, and Washington counties reporting to ESSENCE



* Region 3 includes EDs in Anne Arundel, Baltimore City, Baltimore, Carroll, Harford, and Howard counties reporting to ESSENCE



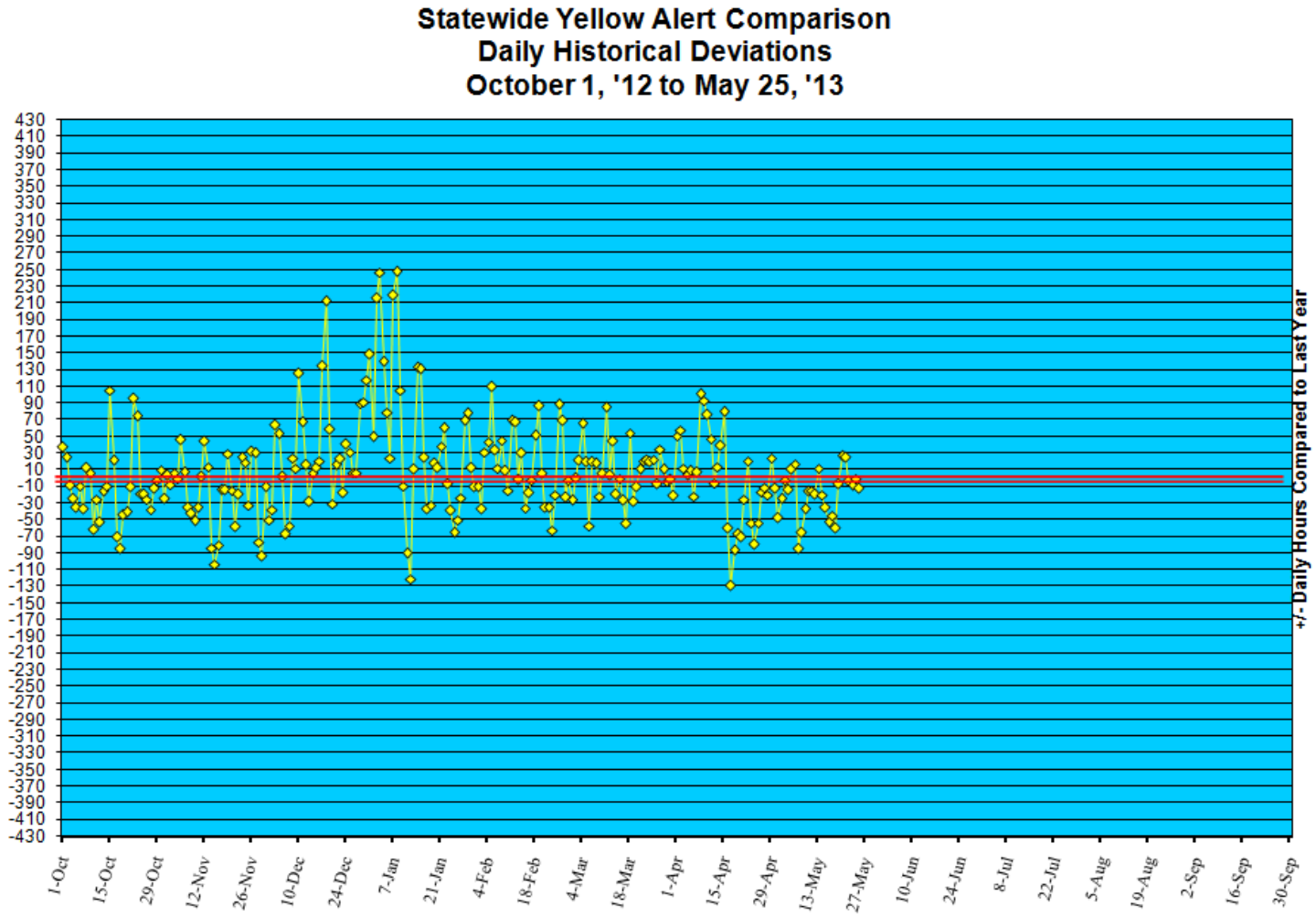
* Region 4 includes EDs in Cecil, Dorchester, Kent, Somerset, Talbot, Wicomico, and Worcester counties reporting to ESSENCE



* Region 5 includes EDs in Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties reporting to ESSENCE

REVIEW OF EMERGENCY DEPARTMENT UTILIZATION

YELLOW ALERT TIMES (ED DIVERSION): The reporting period begins 10/01/11.



REVIEW OF MORTALITY REPORTS

Office of the Chief Medical Examiner: OCME reports no suspicious deaths related to an emerging public health threat for the week.

MARYLAND TOXIDROMIC SURVEILLANCE

Poison Control Surveillance Monthly Update: Investigations of the outliers and alerts observed by the Maryland Poison Center and National Capital Poison Center in April 2013 did not identify any cases of possible public health threats.

REVIEW OF MARYLAND DISEASE SURVEILLANCE FINDINGS

COMMUNICABLE DISEASE SURVEILLANCE CASE REPORTS (confirmed, probable and suspect):

Meningitis:	**Aseptic**	**Meningococcal**
New cases (May 19 – May 25, 2013):	7	0
Prior week (May 12 – May 18, 2013):	9	0
Week#21, 2012 (May 21 – May 27, 2012):	8	0

2 outbreaks were reported to DHMH during MMWR Week 21 (May 19 – May 25, 2013)

1 Gastroenteritis Outbreak
1 outbreak of GASTROENTERITIS associated with a School.

1 Foodborne outbreak
1 outbreak of GASTROENTERITIS/FOODBORNE associated with a Restaurant.

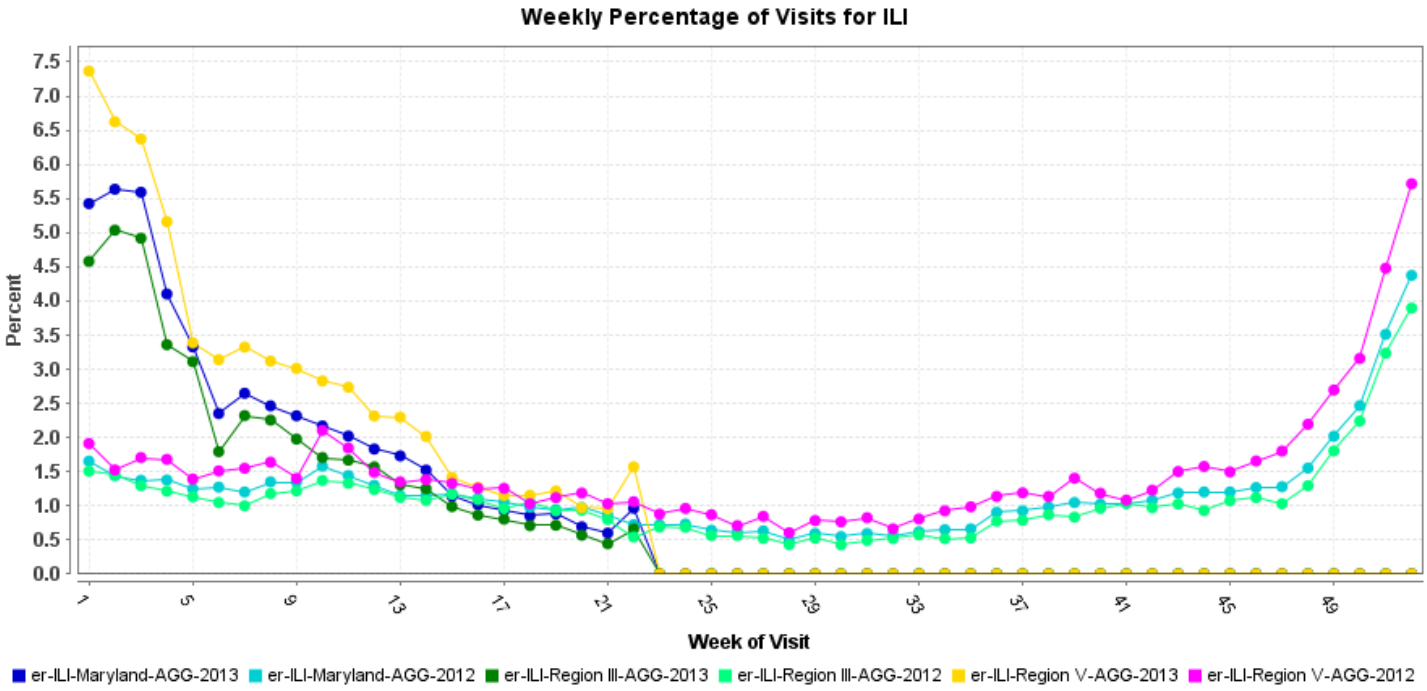
MARYLAND SEASONAL FLU STATUS

Seasonal Influenza reporting occurs October through May. Seasonal influenza activity for Week 21 was: No Activity.

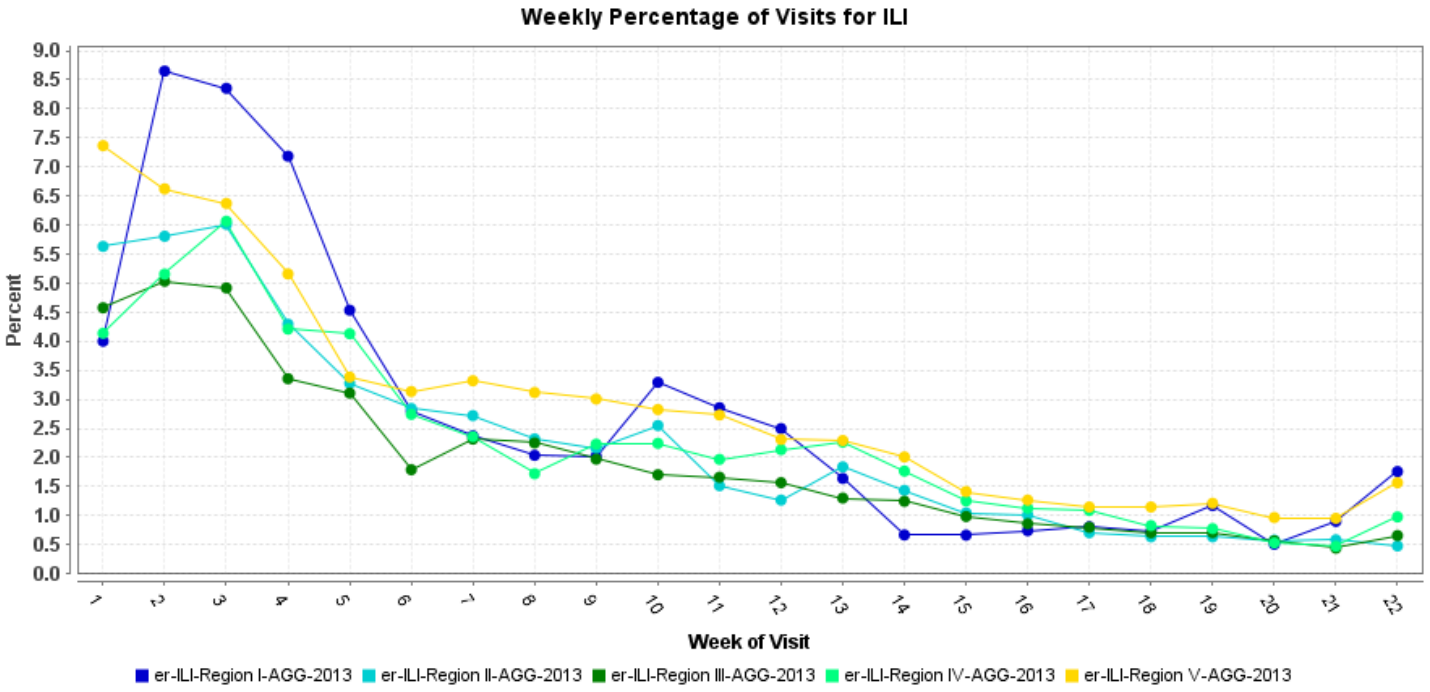
SYNDROMIC SURVEILLANCE FOR INFLUENZA-LIKE ILLNESS

Graphs show the percentage of total weekly Emergency Department patient chief complaints that have one or more ICD9 codes representing provider diagnoses of influenza-like illness. These graphs do not represent confirmed influenza.

Graphs show proportion of total weekly cases seen in a particular syndrome/subsyndrome over the total number of cases seen. Weeks run Sunday through Saturday and the last week shown may be artificially high or low depending on how much data is available for the week.



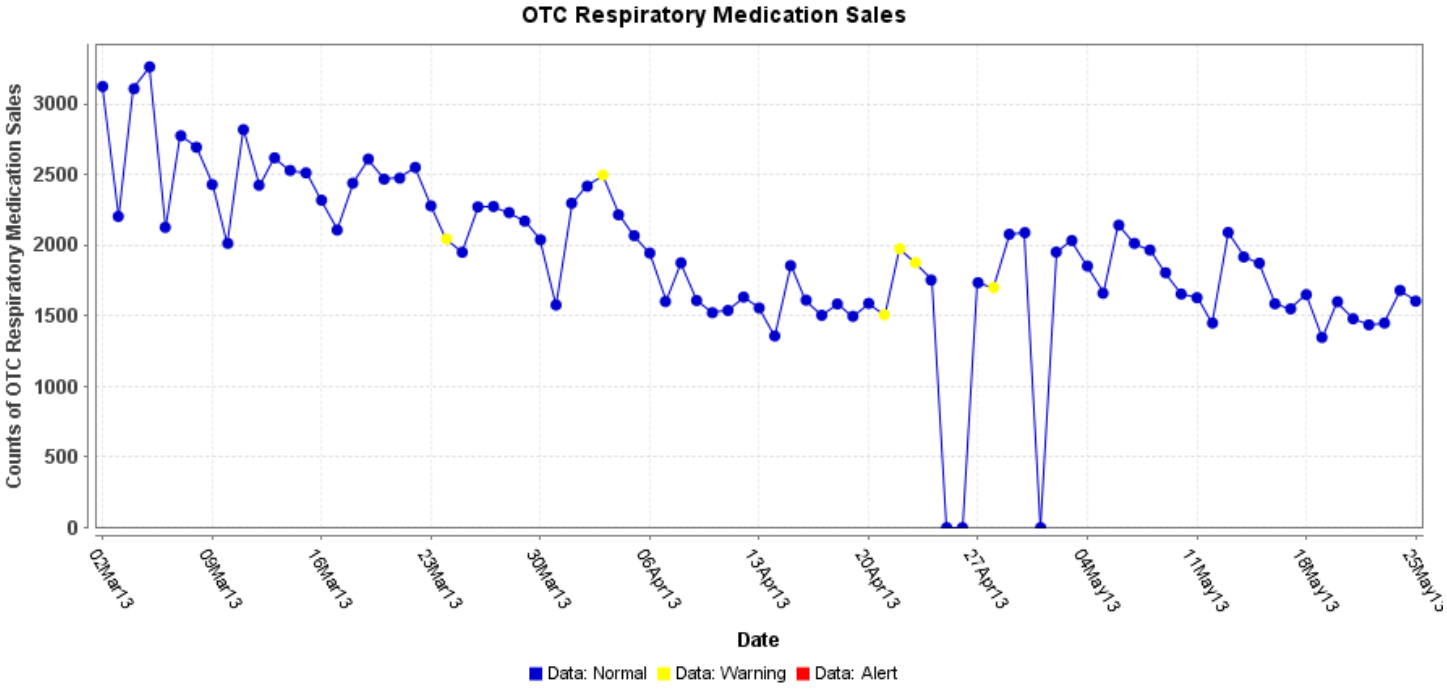
* Includes 2012 and 2013 Maryland ED visits for ILI in Metro Baltimore (Region 3), Maryland NCR (Region 5), and Maryland Total



*Includes 2013 Maryland ED visits for ILI in Region 1, 2, 3, 4, and 5

OVER-THE-COUNTER (OTC) SALES FOR RESPIRATORY MEDICATIONS:

Graph shows the daily number of over-the-counter respiratory medication sales in Maryland at a large pharmacy chain.



PANDEMIC INFLUENZA UPDATE / AVIAN INFLUENZA-RELATED REPORTS

WHO update: The current WHO phase of pandemic alert for avian influenza is 3. Currently, the avian influenza H5N1 virus continues to circulate in poultry in some countries, especially in Asia and northeast Africa. This virus continues to cause sporadic human infections with some instances of limited human-to-human transmission among very close contacts. There has been no sustained human-to-human or community-level transmission identified thus far.

In **Phase 3**, an animal or human-animal influenza reassortant virus has caused sporadic cases or small clusters of disease in people, but has not resulted in human-to-human transmission sufficient to sustain community-level outbreaks. Limited human-to-human transmission may occur under some circumstances, for example, when there is close contact between an infected person and an unprotected caregiver. However, limited transmission under such restricted circumstances does not indicate that the virus has gained the level of transmissibility among humans necessary to cause a pandemic. As of April 26, 2013, the WHO-confirmed global total of human cases of H5N1 avian influenza virus infection stands at 628, of which 374 have been fatal. Thus, the case fatality rate for human H5N1 is approximately 60%.

NATIONAL DISEASE REPORTS*

HANTAVIRUS (ARIZONA): 23 May 2013, Authorities say a Graham County man has died of complications from the [a] hantavirus [infection], the 1st reported case of the disease this year [2013]. The Graham County Health Department says the 39-year-old man died earlier this month [May 2013], but no additional information was immediately available Wednesday [22 May 2013]. The hantavirus[es can cause] a rare disease that exhibit symptoms similar to the flu including fever, muscle aches, and vomiting [and may progress to a cardiopulmonary syndrome with a high fatality rate]. In Arizona, 34 cases of the virus [infection] have been recorded since 2001. Of those, 38 per cent were fatal. Health experts say there's no specific treatment for hantavirus [infection] and victims should seek medical attention as soon as they notice symptoms. Officials recommend sealing up any openings or crawl spaces around the household that could shelter unwanted rodents and placing traps in areas where rodent droppings have been detected. (Emerging infectious diseases are listed in Category C on the CDC List of Critical Biological Agents) *Non-suspect case

E. COLI EHEC (TEXAS): 21 May 2013, The source of the _E. coli_ [O157] outbreak in Brazos County has been linked to ground beef from a local restaurant, according to a press release from the Brazos County Health Department [BCHD]. Despite requests from News 3, health department officials would not release the name of the restaurant, but they say the restaurant has been fully cooperative during the investigation. Officials say 5 cases of E. coli were confirmed in Brazos County. 5 other cases were investigated due to the criteria of symptoms, but they have not been confirmed. "Control measures have been implemented to prevent further cases including mandatory glove use by employees and continuous monitoring by BCHD," said the Health Department in a press release. The press release goes on to say that, "This was an isolated incident and is not a ongoing threat to public health. It's not known if the cause is due to improper temperature, improper cooking, or cross contamination." The Brazos County Health Department and Texas Department of State Health Services have concluded their investigation at this time. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

E. COLI EHEC (GEORGIA): 21 May 2013, The E. Coli outbreak in Stephens County has grown to 11 confirmed cases, Public Health officials said Mon 20 May 2013. "The Georgia Department of Public Health (GDPH), the North Health District, and the Stephens County Health Department continue to investigate an outbreak of E. coli O157:H7 infections that occurred during early May 2013," said District 2 Public Health spokesman Dave Palmer. Palmer said 10 of the cases were Georgia residents, while the other was a South Carolina resident. 7 of those victims were hospitalized as a result of the infections, with 5 of those diagnosed with a complication called hemolytic uremic syndrome (HUS), he said. Palmer said illness onsets were from 4-8 May 2013. Word of the _E. coli_ outbreak came late last week [week of 13 May 2013]. "Of the 11 cases, 10 patients reported eating at the BBQ Shack in Toccoa during the weekend of 2-4 May 2013," Palmer said. "No other common exposures were reported among case-patients." So far, it appears all cases began prior to 8 May 2013. "Evidence to date indicates that only during the 1st weekend in May (2-4 May) were people at risk for exposure," Palmer said. "No cases have been identified with illness onsets after 8 May 2013." No cause has yet been pinpointed. "The BBQ Shack is working closely with Public Health in the investigation," Palmer said. "Epidemiologic, environmental, and laboratory investigations are ongoing. Investigation includes conducting surveillance for any new cases and interviewing case patients and community members. The exact source of infection has not yet been identified." (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

SALMONELLOSIS (NORTH CAROLINA): 21 May 2013, A salmonellosis outbreak stemming from a Fayetteville hotel has now reached 70 possible cases, 12 of which are out of state. The Cumberland County Department of Public Health says 70 people have reported signs or symptoms consistent with salmonellosis. 5 people have been hospitalized. All seem to have eaten at the All American Sports Bar and Grill and The Cafe Bordeaux within the Holiday Inn Fayetteville-Bordeaux on Owen Drive. The hotel's General Manager Scooter Deal said the 1st 14 reported cases were all staff members at the hotel, including himself. Deal said the health department investigators have asked questions of the restaurant kitchen staff and reviewed how they handled food. They are also checking what foods were shipped to the hotel. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

SALMONELLOSIS, SEROTYPE TYPHIMURIUM (MINNESOTA): 21 May 2013, At least 25 Minnesotans have been sickened with salmonellosis linked to eating a raw Mexican-style cheese, queso fresco [fresh cheese], state health officials said [Mon 20 May 2013]. According to a news release, the Minnesota Department of Health (MDH), the Minnesota Department of Agriculture (MDA), and the City of Minneapolis have been investigating the outbreak and the source of the raw milk used to make the cheese since the 1st cases were detected in late April 2013. MDH confirmed 18 cases of infection with the same strain of Salmonella. An additional 7 cases of illness occurred among family members or other contacts of confirmed cases, but no laboratory specimens were available. The individuals became ill between 28 Mar and 24 Apr 2013. Of the 25 cases, 15 were hospitalized. All have recovered. Many cases reported eating unpasteurized queso fresco purchased or received from an individual who made the product in a private home. Investigators have determined that the individual made home deliveries and also may have sold the product on a street corner near the East Lake Street area of Minneapolis. Anyone who may have purchased or received this product recently should not eat it but should throw it away. Samples of unpasteurized queso fresco collected from the cheese maker were found to contain the same strain of Salmonella as the illnesses. Investigators determined that the milk used to make the cheese was purchased by the cheese maker from a Dakota County farm. Unpasteurized milk samples collected at the farm were also found to match the outbreak strain. Dr. Heidi Kassenborg, director of MDA's Dairy and Food Inspection Division, said the outbreak underscores the dangers of consuming unpasteurized dairy products. "It only takes a few bacteria to cause illness. Milking a cow is not a sterile process and even the cleanest dairy farms can have milk that is contaminated. That's why pasteurization -- or the heat treatment of milk to kill the harmful

pathogens -- is so important," said Kassenborg. Minnesota law allows consumers to purchase raw milk directly from the farm for their own consumption, but it may not be further distributed or sold. Additionally, cheese production facilities need to follow proper food safety laws and regulations, including licensure. Dr. Carlota Medus said the outbreak may be over, as there are no suspect cases pending. However, it may still be possible to see additional cases that have not been reported yet from people who consumed cheese prior to health officials' interventions, which occurred 23-26 Apr 2013. While this particular outbreak may be over, MDA and MDH officials are concerned that this may not be an isolated incident: that there may be other instances of people buying foods like unpasteurized queso fresco prepared by neighbors, friends, or family. "It's important for people to be aware of the inherent risk of consuming any raw dairy product from any source," Medus said. "We encourage people to think carefully about those risks and know that the risks are especially high for young children, pregnant women, the elderly, and those with weakened immune systems." (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

SALMONELLOSIS, SEROTYPE SAINTPAUL (USA): 20 May 2013, A total of 81 persons infected with the outbreak strain of Salmonella [enteric serotype] Saintpaul have been reported from 18 states. Since the last update, 8 new ill persons have been reported from Arizona (2), Minnesota (1), North Carolina (2), Ohio (2), and Virginia (1). This PFGE pattern has rarely been seen before in PulseNet and in the past typically caused 0-5 cases per year. Among persons for whom information was available, illness onset dates range from 12 Jan 2013 to 19 Apr 2013. Ill persons range in age from less than 1 year to 89 years, with a median age of 27 years. 63 percent of ill persons are female. Among 56 persons with available information, 16 (29 percent) ill persons have been hospitalized. No deaths have been reported. Preliminary epidemiologic, laboratory, and traceback investigations conducted by officials in local, state, and federal public health, agriculture, and regulatory agencies indicate that exposure to imported cucumbers supplied by Daniel Cardenas Izabal and Miracle Greenhouse of Culiacan, Mexico and distributed by Tricar Sales, Inc. of Rio Rico, Arizona is the likely source of this outbreak of S. Saintpaul infections. In interviews, ill persons answered questions about foods eaten and other exposures during the week before becoming ill. 30 (67 percent) of 45 ill persons interviewed reported eating various types of cucumbers purchased or consumed at multiple locations or restaurants. This proportion is significantly higher than results from a survey of healthy persons in which 44 percent reported eating cucumbers in the 7 days before they were interviewed. An additional 5 (11 percent) of 45 ill persons reported that they may have eaten cucumbers. No other foods that were reported eaten by interviewees were associated with illness. Reviewing shipping records, with assistance from its partner state agencies, FDA traced cucumbers eaten by 6 ill people to the distributer, Tricar Sales, Inc., and further, to the suppliers, Daniel Cardenas Izabal and Miracle Greenhouse. On 24 Apr 2013, the suppliers were placed on Import Alert. Cucumbers from these 2 firms will be denied admission into the USA unless the suppliers show that they are not contaminated. The number of illnesses reported has declined substantially since a peak in early March 2013. Currently, there is no evidence that contaminated cucumbers are still on the market. However, due to the time it takes between when a person becomes ill and when the illness is reported, additional ill persons may be identified. CDC and state and local public health partners are continuing laboratory surveillance through PulseNet to identify additional ill persons and to interview ill persons about foods eaten with before becoming ill. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

INTERNATIONAL DISEASE REPORTS*

CRIMEAN-CONGO HEMORRHAGIC FEVER (RUSSIA): 25 May 2013, According to Rospotrebnadzor [The Federal Service for Consumer Rights and Human Welfare], as of 20 May 2013, 7 laboratory confirmed cases of Crimean-Congo hemorrhagic fever [CCHF] have been reported in the Rostov Region; 4 cases were recorded in the Salsk district region, 2 in the Proletarsk district, and one in the Martynovsky district. The situation with regard to CCHF in the Rostov region is worrying. The majority of municipalities lie in territory that includes natural foci of CCHF infection. According to Rospotrebnadzor, last month [April 2013], 403 persons, including 124 children under 14 years old, sought treatment for tick bites. The largest number of such cases were registered in the Rostov-on-Don, Volgodonsk, Taganrog, Salsk, Peschanokopsk, Semikarakorsk, Tselinsky and Salsk areas. The natural foci of [the ticks responsible for transmission of] CCHF virus infection include steppe, semi-desert, and forest-steppe landscapes of the south of Russia: including Kalmykia, Dagestan, Ingushetia, Karachaevo-Cherkessia and Kabardino-Balkaria, Krasnodar, Stavropol , Rostov, Volgograd, and Astrakhan regions. (Viral Hemorrhagic Fevers are listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

MERS-COV (SAUDI ARABIA): 23 May 2013, The Ministry of Health in Saudi Arabia has notified WHO of an additional laboratory-confirmed case of infection with the Middle East respiratory syndrome coronavirus (MERS-CoV). The fatal case was reported from Al-Qaseem region in the Central part of the country and is not related to the cluster of cases reported from Al-Ahsa region in the eastern part of the country. The patient was a 63-year-old man with an underlying medical condition who was admitted to a hospital with acute respiratory distress on 15 May 2013 and died on 20 May 2013. Investigation into contacts of this case is ongoing. The Saudi authorities are also continuing the investigation into the outbreak that began in a health care facility since the beginning of April 2013 in Al-Ahsa. To date, a total of 22 patients including 10 deaths have been reported from the outbreak. Globally, from September 2012 to date, WHO has been informed of a total of 44 laboratory-confirmed cases of infection with MERS-CoV, including 22 deaths. WHO has received reports of laboratory-confirmed cases from the following countries in the Middle East: Jordan, Qatar, Saudi Arabia, and the United Arab Emirates (UAE). France, Germany, Tunisia and the United Kingdom also reported laboratory-confirmed cases; they were either transferred for care of the disease or returned from the Middle East and subsequently became ill. In France, Tunisia and the United Kingdom, there has been limited local transmission among close contacts who had not been to the Middle East but had been in close contact with the laboratory-confirmed or probable cases. Based on the current situation and available information, WHO encourages all Member States to continue their surveillance for severe acute respiratory infections (SARI) and to carefully review any unusual patterns. Health care providers are advised to maintain vigilance. Recent travelers returning from the Middle East who develop SARI should be tested for MERS-CoV as advised in the current surveillance recommendations. Specimens from patients' lower respiratory tracts should be obtained for diagnosis where possible. Clinicians are reminded that MERS-CoV infection should be considered even with atypical signs and symptoms, such as diarrhea, in patients who are immunocompromised. Health care facilities are reminded of the importance of systematic implementation of infection prevention and control (IPC). Health care facilities that provide care for patients suspected or confirmed with MERS-CoV infection should take appropriate measures to decrease the risk of transmission of the virus to other patients, health care workers and visitors. All Member States are reminded to promptly assess and notify WHO of any new case of infection with MERS-CoV, along with information about potential exposures that may have resulted in infection and a description of the clinical course. Investigation into the source of exposure should promptly be initiated to identify the mode of exposure so that further transmission of the virus can be prevented. WHO does not advise special screening at points of entry with regard to this event nor does it currently recommend the application of any travel or trade restrictions. WHO continues to closely monitor the situation. (Emerging infectious diseases are listed in Category C on the CDC List of Critical Biological Agents) *Non-suspect case

*National and International Disease Reports are retrieved from http://www.promedmail.org/.

OTHER RESOURCES AND ARTICLES OF INTEREST

More information concerning Public Health and Emergency Preparedness can be found at the Office of Preparedness and Response website: http://preparedness.dhmh.maryland.gov/

Maryland's Resident Influenza Tracking System: http://dhmh.maryland.gov/flusurvey

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NOTE: This weekly review is a compilation of data from various surveillance systems, interpreted with a focus on a potential BT event. It is not meant to be inclusive of all epidemiology data available, nor is it meant to imply that every activity reported is a definitive BT event. International reports of outbreaks due to organisms on the CDC Critical Biological Agent list will also be reported. While not "secure", please handle this information in a professional manner. Please feel free to distribute within your organization, as you feel appropriate, to other professional staff involved in emergency preparedness and infection control.

For questions about the content of this review or if you have received this and do not wish to receive these weekly notices, please e-mail me. If you have information that is pertinent to this notification process, please send it to me to be included in the routine report.

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Table: Text-based Syndrome Case Definitions and Associated Category A Conditions

Syndrome	Definition	Category A Condition
Botulism-like	ACUTE condition that may represent exposure to botulinum toxin ACUTE paralytic conditions consistent with botulism: cranial nerve VI (lateral rectus) palsy, ptosis, dilated pupils, decreased gag reflex, media rectus palsy. ACUTE descending motor paralysis (including muscles of respiration) ACUTE symptoms consistent with botulism: diplopia, dry mouth, dysphagia, difficulty focusing to a near point.	Botulism
Hemorrhagic Illness	SPECIFIC diagnosis of any virus that causes viral hemorrhagic fever (VHF): yellow fever, dengue, Rift Valley fever, Crimean-Congo HF, Kyasanur Forest disease, Omsk HF, Hantaan, Junin, Machupo, Lassa, Marburg, Ebola ACUTE condition with multiple organ involvement that may be consistent with exposure to any virus that causes VHF ACUTE blood abnormalities consistent with VHF: leukopenia, neutropenia, thrombocytopenia, decreased clotting factors, albuminuria	VHF
Lymphadenitis	ACUTE regional lymph node swelling and/ or infection (painful bubo- particularly in groin, axilla or neck)	Plague (Bubonic)
Localized Cutaneous Lesion	SPECIFIC diagnosis of localized cutaneous lesion/ ulcer consistent with cutaneous anthrax or tularemia ACUTE localized edema and/ or cutaneous lesion/ vesicle, ulcer, eschar that may be consistent with cutaneous anthrax or tularemia INCLUDES insect bites EXCLUDES any lesion disseminated over the body or generalized rash EXCLUDES diabetic ulcer and ulcer associated with peripheral vascular disease	Anthrax (cutaneous) Tularemia
Gastrointestinal	ACUTE infection of the upper and/ or lower gastrointestinal (GI) tract SPECIFIC diagnosis of acute GI distress such as Salmonella gastroenteritis ACUTE non-specific symptoms of GI distress such as nausea, vomiting, or diarrhea EXCLUDES any chronic conditions such as inflammatory bowel syndrome	Anthrax (gastrointestinal)

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents
(continued from previous page)

Syndrome	Definition	Category A Condition
Respiratory	ACUTE infection of the upper and/ or lower respiratory tract (from the oropharynx to the lungs, includes otitis media) SPECIFIC diagnosis of acute respiratory tract infection (RTI) such as pneumonia due to parainfluenza virus ACUTE non-specific diagnosis of RTI such as sinusitis, pharyngitis, laryngitis ACUTE non-specific symptoms of RTI such as cough, stridor, shortness of breath, throat pain EXCLUDES chronic conditions such as chronic bronchitis, asthma without acute exacerbation, chronic sinusitis, allergic conditions (Note: INCLUDE *acute exacerbation* of chronic illnesses.)	Anthrax (inhalational) Tularemia Plague (pneumonic)
Neurological	ACUTE neurological infection of the central nervous system (CNS) SPECIFIC diagnosis of acute CNS infection such as pneumoccocal meningitis, viral encephailitis ACUTE non-specific diagnosis of CNS infection such as meningitis not otherwise specified (NOS), encephailitis NOS, encephalopathy NOS ACUTE non-specific symptoms of CNS infection such as meningismus, delerium EXCLUDES any chronic, hereditary or degenerative conditions of the CNS such as obstructive hydrocephalus, Parkinson's, Alzheimer's	Not applicable
Rash	ACUTE condition that may present as consistent with smallpox (macules, papules, vesicles predominantly of face/arms/legs) SPECIFIC diagnosis of acute rash such as chicken pox in person > XX years of age (base age cut-off on data interpretation) or smallpox ACUTE non-specific diagnosis of rash compatible with infectious disease, such as viral exanthem EXCLUDES allergic or inflammatory skin conditions such as contact or seborrheaic dermatitis, rosacea EXCLUDES rash NOS, rash due to poison ivy, sunburn, and eczema	Smallpox
Specific Infection	ACUTE infection of known cause not covered in other syndrome groups, usually has more generalized symptoms (i.e., not just respiratory or gastrointestinal) INCLUDES septicemia from known bacteria INCLUDES other febrile illnesses such as scarlet fever	Not applicable

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents (continued from previous page)

Syndrome	Definition	Category A Condition
Fever	ACUTE potentially febrile illness of origin not specified INCLUDES fever and septicemia not otherwise specified INCLUDES unspecified viral illness even though unknown if fever is present EXCLUDE entry in this syndrome category if more specific diagnostic code is present allowing same patient visit to be categorized as respiratory, neurological or gastrointestinal illness syndrome	Not applicable
Severe Illness or Death potentially due to infectious disease	ACUTE onset of shock or coma from potentially infectious causes EXCLUDES shock from trauma INCLUDES SUDDEN death, death in emergency room, intrauterine deaths, fetal death, spontaneous abortion, and still births EXCLUDES induced fetal abortions, deaths of unknown cause, and unattended deaths	Not applicable